**New York State Office of the State Comptroller**
Thomas P. DiNapoli

Division of State Government Accountability

# Improper Managed Care Payments for Certain Medicaid Recipients

## Medicaid Program
## Department of Health

Report 2010-S-66 July 2012

# Executive Summary

## Purpose

To determine if the Department of Health (Department) made Medicaid managed care payments for foster and long-term care recipients who were not eligible for managed care programs. The audit covers the period from July 1, 2005 through June 30, 2010.

## Background

Many localities use managed care programs to provide Medicaid services. For the five years ending June 30, 2010, the State spent nearly $38 billion for Medicaid managed care services. However, State law specifically precludes certain categories of recipients from participation in managed care programs. These exclusions include children whose medical care is covered under the foster care daily rate program and individuals who receive services in long-term care settings (such as State-operated psychiatric centers and residential treatment facilities).

## Key Findings

- For the five years ended June 30, 2010, Medicaid made $15.6 million in improper managed care payments on behalf of 14,899 recipients who, by State law, were precluded from enrollment in managed care programs.
- About $14.4 million (of the $15.6 million) in improper payments were attributable to 13,002 recipients with multiple Medicaid identification numbers.
- The remaining $1.2 million in improper payments related to 1,897 recipients with only one identification number.

## Key Recommendations

- Investigate the $15.6 million in improper Medicaid managed care payments identified in this audit and recover funds, where possible and appropriate.
- Direct the local districts, particularly the New York City Human Resources Administration to take the steps necessary to prevent the issuance of multiple identification numbers to Medicaid recipients.
- Strengthen steps to oversee and monitor Medicaid managed care enrollments.

## Other Related Audits/Reports of Interest

Department of Health: Improper Medicaid Payments for Recipients with Multiple Identification Numbers (2008-S-163)

Department of Health: Multiple Medicaid Payments for Managed Care Recipients (2004-S-48)

# State of New York
# Office of the State Comptroller

## Division of State Government Accountability

July 24, 2012

Nirav R. Shah, M.D., M.P.H.
Commissioner
Department of Health
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Empire State Plaza
Albany, New York 12237

Dear Dr. Shah:

The Office of the State Comptroller is committed to helping State agencies, public authorities and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls intended to safeguard assets.

Following is a report of our audit of the Medicaid Program entitled *Improper Managed Care Payments for Certain Medicaid Recipients.* This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

*Office of the State Comptroller*
*Division of State Government Accountability*

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# Background

Medicaid is a federal, state, and local government program which provides medical care to qualified individuals. The Centers for Medicare and Medicaid Services oversee the program on a national level, and the Department of Health (Department) is responsible for the program at the state level. New York has 58 local social services districts (local districts) which represent the counties throughout the State, except New York City - where the five boroughs comprise one local district. The Department provides oversight and establishes guidelines for the local districts regarding Medicaid. When a locality registers someone for Medicaid, the locality assigns that person a discrete Medicaid identification number, which is required for recipients to obtain medical services and for providers to bill for such services.

In recent years, the Medicaid program grew significantly with enrollments increasing from 4.6 million persons in 2007 to 5.2 million persons in 2010; an increase of almost 600,000 enrollees. Between March 31, 2008 and March 31, 2011, annual Medicaid costs increased by about $10 billion and totaled $53 billion for the year ended March 31, 2011. In some instances, Medicaid pays providers directly under fee-for-service arrangements. In other instances, Medicaid recipients enroll with a managed care organization (MCO), and the MCO charges Medicaid directly for a monthly premium for each enrolled recipient. The MCO then provides or arranges for a comprehensive range of standard health care services for the enrollees. Generally, the costs of nearly all services required by a managed care recipient are covered by the monthly premiums paid to the MCO. However, in limited circumstances, managed care recipients can require services provided under a fee-for-service basis.

Local social services districts determine if recipients meet Medicaid eligibility requirements, enroll recipients in fee-for service or managed care programs, and change enrollments depending upon changes in recipients' eligibility status. Currently, 47 local districts require most Medicaid recipients to be enrolled in managed care. In these districts, recipients can choose a particular MCO, or the district selects an MCO for them. However, State law prohibits certain Medicaid recipients from enrollment in managed care programs. The excluded recipients include: foster care children covered by a daily rate program; youth in residential treatment facilities; and individuals admitted to long-term care hospitals and State-operated psychiatric centers.

As of April 2011, about three million Medicaid recipients were enrolled in managed care statewide. During the five years ending June 30, 2010, the State spent nearly $38 billion for Medicaid managed care. The Department processes and pays Medicaid claims through an automated system, known as eMedNY.

# Audit Findings and Recommendations

## Improper Payments

During the five years ending June 30, 2010, Medicaid made 105,767 managed care premium payments totaling $15.6 million that were improper because the payments were made on behalf of 14,899 recipients who were specifically precluded by the State Public Health Law (Law) from enrollment in managed care. The majority of the improper managed care payments were attributable to 13,002 (of the 14,899) recipients, who were enrolled in Medicaid more than once and, consequently, had multiple Medicaid identification numbers.

Of the 105,767 improper managed care payments, 96,066 of them (totaling 13.4 million) were for 12,474 recipients who were also covered by Medicaid's foster care daily rate program. Under this program, Medicaid pays foster care agencies a daily rate based on medical care costs that the providing agencies report to the Department. The daily rate covers many medical services, including those provided by physicians, psychiatrists, nurses, and pharmacies. Services not covered by the foster care daily rate program are covered by Medicaid under fee-for-service reimbursements. However, the Law prohibits Medicaid managed care enrollment for children covered by the Medicaid foster care daily rate program. Therefore, the $13.4 million of managed care premium payments made on behalf of the 12,474 recipients covered by the foster care daily rate program were improper.

These improper payments resulted from duplicate enrollments, which took place primarily in New York City. There, local officials used one Medicaid identification number to enroll a child in managed care and a different identification number to enroll the same child for payments under the daily rate program. For example, using one identification number, Medicaid paid a foster care agency nearly $11,000 from April 2007 through June 2010 under the daily rate program - and, using another identification number, Medicaid paid a managed care plan $13,787 in premiums to cover the same child during the same period. We requested local district officials to investigate this case, and the officials closed-out one identification number and obtained a refund of $13,787 from the managed care plan.

We also found that 4,286 of the remaining improper managed care payments (totaling $1 million) were attributable to 528 recipients covered by Medicaid reimbursement rates for long-term care at a State psychiatric center, residential treatment facility, or long-term care hospital. The Law precludes these individuals from also being enrolled in Medicaid managed care, and therefore, these Medicaid managed care premium payments were also improper. For example, a child was admitted to a residential treatment facility under one Medicaid identification number and was enrolled in a managed care plan under another number. Because the child was covered through Medicaid payments to the residential care facility, the child was not eligible for enrollment in managed care. This duplicative and improper managed care coverage resulted in $2,500 of improper Medicaid managed care premium payments.

These improper enrollments, using multiple identification numbers for the same person, were

primarily attributable to a lack of oversight by two New York City Agencies – the Administration for Child Services (ACS) and the Human Resource Administration (HRA). ACS establishes Medicaid identification numbers for children under the foster care daily rate program in New York City, and HRA establishes Medicaid identification numbers for children enrolling in Medicaid managed care, fee for service care or coverage under a residential program. However, neither agency was adequately researching that the same individuals were not already enrolled in Medicaid at the time they created a new identification number. Moreover, we also noted that while eMedNY produces many reports to help identify individuals with multiple identification numbers, the reports are not designed to identify someone with multiple numbers when one number pertains to managed care and another pertains to a foster care daily rate program.

The problems we identified in this audit have plagued Medicaid for years. We previously notified the Department of recipients with multiple identification numbers in audit reports 2004-S-48 (Multiple Medicaid Payments for Managed Care Recipients, issued February 7, 2006), and 2008-S-163 (Improper Medicaid Payments for Recipients with Multiple Identification Number, issued December 22, 2009). In these two audits, we identified about $98 million in Medicaid in overpayments resulting from people with multiple identification numbers. Nevertheless, problems with this matter persist.

The remaining $1.2 million (of the total $15.6 million) in improper payments pertained to 5,415 managed care claims for 1,897 people with only one Medicaid identification number. These recipients were placed in long-term care facilities or foster care programs which provided health care under the daily rate program, and they were no longer eligible for managed care coverage. Generally, the Department relies on the local districts to remove recipients from managed care programs when they no longer qualify for them. Further, long-term care facilities, foster care providers, and MCOs should notify local districts when recipients no longer qualify for managed care.

Sometimes, however, these notifications were not made. Hence, local district workers were unaware that certain Medicaid recipients were in long-term or foster care settings - and therefore, the districts did not remove such recipients from managed care programs. For example, from July 1, 2007 through October 31, 2009, Medicaid paid a long-term care facility over $487,000 for a recipient. During the same period, however, Medicaid also paid $14,054 for the same recipient's enrollment in managed care. We notified local officials of this error, and they obtained a refund of $14,054 from the MCO.

We also attribute the overpayments we identified to limitations in Department efforts to oversee and monitor local districts' removal of persons from managed care programs when they are no longer eligible for them. For example, the Department did not formally analyze managed care enrollments periodically to identify persons who should be removed from managed care programs. Further, the Department did not formally determine (or require the local districts to determine) why certain managed care recipients had multiple identification numbers. Consequently, local districts continued to issue multiple identification numbers to recipients - and the resulting problems often were not detected and resolved timely.

Particularly given the State's current financial problems, the Department should take steps as needed to prevent improper payments, such those detailed in this report, from recurring in the future.

## Recommendations

1. Investigate the $15.6 million in improper Medicaid managed care payments identified in this audit and recover funds where possible and appropriate.

2. Direct that ACS and local districts, particularly the New York City HRA, take the steps necessary to prevent the issuance of multiple identification numbers to Medicaid recipients. The steps should include (but not be limited to) verification that a Medicaid applicant does not already have a Medicaid identification number.

3. Develop and implement Medicaid exception reports which detail payments for a recipient with multiple identification numbers, when one identification number is linked to managed care and the other to a daily rate for foster care.

4. Formally remind long-term care providers, foster care programs, and MCOs to advise local district officials when recipients are no longer eligible for managed care services.

5. Strengthen steps to oversee and monitor Medicaid managed care enrollments. The steps should include (but not be limited to):

    - periodic formal analyses of managed care enrollments to identify persons who should be excluded from such programming;
    - formal determination of the reasons why local districts issue multiple identification numbers to certain recipients; and
    - reminders to local districts to resolve timely the matter of recipients with multiple identification numbers, particularly in relation to managed care.

# Audit Scope and Methodology

We audited whether the Department made managed care payments for foster and long-term care Medicaid recipients who were not eligible for enrollment in managed care. Our audit period was July 1, 2005 through June 30, 2010.

To accomplish our objectives, we interviewed officials from the Department, local districts and medical providers. We also reviewed applicable sections of Federal and State laws and regulations. We extracted Medicaid payment information from the Medicaid claims processing system for recipients receiving selected long-term care services. These services include inpatient services in a state-operated psychiatric center, a residential treatment facility or a long-term care hospital as well as services provided to children in foster care. Further, to identify instances of duplicate coverage, we identified Medicaid identification numbers for the same social security number and

the same or similar names and dates of birth.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

# Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

# Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of it. In their response, Department officials generally concurred with our recommendations and indicated that certain actions are planned or have been taken to address them. These actions include taking steps to limit the creation of duplicate Medicaid identification numbers and working with the local districts and OMIG to recover inappropriate payments resulting from such duplication.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

# Contributors to This Report

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## Vision

A team of accountability experts respected for providing information that decision makers value.

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To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

# Agency Comments

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

May 30, 2012

Mr. Brian E. Mason
Audit Director
Office of the State Comptroller
Division of State Government Accountability
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Dear Mr. Mason:

Enclosed are the New York State Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2010-S-66 on "Improper Managed Care Payments for Certain Medicaid Recipients."

Thank you for the opportunity to comment.

Sincerely,

Robert W. LoCicero, Esq.
Deputy Director for Administration

Enclosure

cc: Sue E. Kelly
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# Department of Health
# Comments on the
# Office of the State Comptroller's
# Draft Audit Report 2010-S-66 on
# "Improper Managed Care Payments
# for Certain Medicaid Recipients"

The following are the Department of Health's (Department) comments in response to Office of the State Comptroller (OSC) Draft Audit Report 2010-S-66 on "Improper Managed Care Payments for Certain Medicaid Recipients."

**Recommendation #1**:

Investigate the $15.6 million in improper Medicaid managed care payments identified in this audit and recover funds where possible and appropriate.

**Response #1:**

The Office of the Medicaid Inspector General (OMIG) is currently reviewing data and will consult with the Department in assessing the recoverability of the $15.6 million in potential overpayments identified by OSC, and will then pursue recoveries as warranted.

**Recommendation #2:**

Direct that the Administration for Child Services (ACS) and local districts, particularly the New York City Human Resource Administration (HRA), take the steps necessary to prevent the issuance of multiple identification numbers to Medicaid recipients. The steps should include, (but not be limited to) verification that a Medicaid applicant does not already have a Medicaid identification number.

**Response #2:**

The Department has taken the following steps to either limit the creation of a duplicate CIN or to reduce/recover the instances where there are multiple payments for the duplicate CINs:

- revised the Access NY application to inquire if applicants have had prior public health insurance coverage to permit the local district to further probe whether an existing CIN is available for use in the current case;

- implemented enrollment systems modifications whereby the enrollment broker utilized by the Department for assigning eligible applicants to plans will reject cases for assignment when the existence of a prior or current CIN is discovered, thereby eliminating two managed care payments;

- amended its contracts with the health plans as follows: "Notwithstanding the foregoing, the Department always has the right to recover duplicate Medicaid Managed Care (MMC) or Family Health Plus (FHPlus) premiums paid for persons enrolled in the MMC or FHPlus program under more than one CIN whether or not the contractor has made payments to providers."

Additionally, the Department will continue to issue guidance to all local districts, including HRA, on issues relevant to duplicate identification numbers, including those involving applicants that do not have a social security number. The selection and assignment of Client Identification Numbers (CINs) will also be incorporated into refresher and new worker training sessions for local district staff. The Department is also drafting a General Information System Message (GIS) to transmit to all local districts, including HRA, addressing the assignment of CINs. It anticipates transmitting the GIS early Summer 2012.

Further, HRA published guidance on CIN selection in its September 2011 edition of The Medical Assistance Program Journal. This included a review of the CIN assignment process, and highlighted the newborn issue: "When there is a 101 match and the individual is less than 1 year old and has a Social Security Number (SSN), a further investigation is to be made, as most newborns already in Welfare Management System (WMS) do not have an SSN and therefore, duplicate CINs will appear as a 101 match."

**Recommendation #3:**

Develop and implement Medicaid exception reports which detail payments for a recipient with multiple identification numbers, when one identification number is linked to managed care and the other to a daily rate for foster care.

**Response #3:**

The Department already generates bi-monthly duplicate CIN reports which are forwarded to local districts, including HRA, for follow-up and CIN closure where appropriate. In addition, under Medicaid Redesign Team Proposal #1458, institutionalized foster care will be brought into the mandatory managed care population by April 1, 2015. While implementation of the MRT proposal will resolve the OSC findings, the Department will evaluate whether an additional report specifically addressing the OSC findings can be created for the interim period.

**Recommendation #4:**

Formally remind long-term care providers, foster care programs, and managed care organizations (MCOs) to advise local district officials when recipients are no longer eligible for managed care services.

**Response #4:**

The Department will include an article in its Medicaid Update monthly provider publication reminding long-term care providers, foster care programs and managed care organizations to advise local district officials when recipients are no longer eligible for managed care services. It will additionally contact the State Office for Family and Children Services for another means of advising foster care programs, as well as address the subject in its monthly operational issues meeting with managed care plans.

**Recommendation #5:**

Strengthen steps to oversee and monitor Medicaid managed care enrollments. The steps should include (but not be limited to):

- periodic formal analyses of managed care enrollments to identify persons who should be excluded from such programming;
- formal determination of the reasons why local districts issue multiple identification numbers to certain recipients; and
- reminders to local districts to resolve timely the matter of recipients with multiple identification numbers, particularly in relation to managed care.

**Response #5:**

The Department continually works with the local districts and OMIG on duplicate identification and recovery projects. As of December 2009, local districts receive Department reports identifying recipients which are enrolled in managed care plans and potentially have duplicate CINs (Recipient Duplicate Report-PCP Only). Local districts are expected to verify the report's matches and to take action as warranted, including closing cases and/or disenrolling recipients from managed care and recovering premiums.

In August of 2010, the Department instituted procedures that modified enrollment systems whereby the enrollment broker uses a matching process to reject cases for assignment when it discovers an existing CIN, thereby eliminating two managed care payments. At this time, WMS implemented a similar process in non-enrollment broker counties to prevent batch enrollment into managed care of a CIN meeting duplicate CIN criteria. Additionally, WMS will be adding "SERMA" (e.g., foster care children) matches to the monthly New York City and Statewide Multiple CIN reports. Previously, these foster care potential duplicates were not reported.

Department review highlighted some of the reasons for the issuance of multiple CINs, which are summarized below.

- An unborn child of a mother who is a Medicaid recipient is given Medicaid eligibility when the mother's pregnancy is documented. Should the child lose eligibility and later reapply, the clearance process may not identify the child as having previously been enrolled in Medicaid because a social security number (SSN) was not provided at the time eligibility was given as an unborn.

- When a pregnant woman or an undocumented alien who does not have a SSN loses eligibility and reapplies, the clearance process may not identify the individual as having been previously enrolled because the SSN is the primary matching variable.

- The Upstate and NYC Welfare Management Systems are independent. Consequently, local district staff must utilize the cross-district identification function to verify whether an applicant has had prior eligibility whenever a recipient moves between Upstate and NYC.

Finally, local districts are forwarded periodic reminders to timely resolve matters of recipients with multiple CINs, with the latest issued in November 2011. Additionally, a new process is being implemented this month whereby reminders (lists) will be posted to the Human Services Enterprise Network (HSEN) for districts to access directly.